PRINTED: 08/30/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED	
		155287	B. WIN			08/08/2	2011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8		1			
DENICOE	LACD CADE CENT	TED		1	GRACE ST		
KEN55E	LAER CARE CENT	ER		RENSS	SELAER, IN47978		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
F0000	This visit was fo State Licensure Survey dates: August 1, 2, 3, 4 Facility number: Provider number AIM number: Survey team: Regina Sanders, Heather Tuttle, Fe 2011) Lara Richards, Re 2011) Kitty Vargas, RNe 2011) Census bed type SNF/NF: 107 Total: 107 Census Payor type Medicare: 14 Medicaid: 76 Other: 17 Total: 107 Sample: 22	r a Recertification and Survey. , 5, and 8, 2011 000185 :: 155287 100290840 RN, TC RN (August 2, 3, 4, and 5, 4) (August 2, 3, 4, and 5, 5) I (August 2, 3, 4, and 5, 5) :: pe:	FO	0000	8.22.11This Plan of Correcti submitted as required under Federal and State regulation statues applicable to long te care providers. This Plan of Correction does not constitu admission of liability on the the facility, and such liability hereby specifically denied. It submission of the plan does constitute an agreement by facility that the surveyors' fir or conclusions are accurate the findings constitute a deficiency, or that the scope severity regarding any of the deficiencies cited are correct applied. Please accept this pas our credible allegation of compliance.	n and rm te an part of is The not the idings that e or e tly	
	Supplemental sa	ilipie. I					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SM4M11

Facility ID:

000185

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLI	ETED
		155287	B. WING		08/08/20	011
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	Ī	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	These deficiencie	es reflect state findings			Ĭ	
	cited in accordan	ice with 410 IAC 16.2.				
F0157 SS=D	Quality review 8/10 A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant changemental, or psychosocial statuconditions or clinical alter treatment significant change mental, or psychosocial statuconditions or clinical terms or clinical alter treatment significant in a condition or clinical treatment in the condition of the condition	/11 by Suzanne Williams, RN nediately inform the vith the resident's physician; by the resident's legal an interested family member accident involving the sults in injury and has the ring physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening cal complications); a need to nificantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to age the resident from the d in §483.12(a). Ilso promptly notify the own, the resident's legal interested family member range in room or roommate ecified in §483.15(e)(2); or ent rights under Federal or ations as specified in				
	update the addres	ecord and periodically is and phone number of the presentative or interested	F0157	F 157		08/31/2011
	facility failed to	review and interview, the notify residents' w blood sugar results for	10137	1. Corrective action For resident 24 and 36 physi were notified regarding low b		00/31/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155287	B. WIN			08/08/2	011
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	3		1	GRACE ST		
RENSSE	LAER CARE CENT	rep		1	ELAER, IN47978		
	LALIN CAINL CLIN	ILK			ELALIX, IN47970		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	2 of 7 residents	with glucometer (blood			sugars. Resident 24 had	ام	
	sugar) checks in a sample of 22.				physician notified on Aug 2 r 2011 and 36 physician was	ia,	
	(Residents				notified July 28 th, 2011, wit	h	
	#24 and #36)				documentation for both in reg		
	ĺ				to notification found in the cli	•	
	Findings include	<u>.</u>			record.		
	i mamgs merade				2. Identification of others		
	1 D :1				potentially affected		
		s record was reviewed on			On August 19 th , 2011 a 100		
	_	m. The resident's			audit was conducted for resid		
	diagnoses includ	led, but were not limited			requiring accu checks by nur		
	to, diabetes mell	itus and hypertension.			management. No resident fo to require MD notification. BI		
					sugars within parameters.	oou	
	The Physician's	Recapitulation Orders,			3. Systemic changes		
		icated an order, which			In service with education pro	vided	
	l '	/16/11, to administer a			to licensed nurses on 8.18.1		
	"	·			staff development coordinate		
	~	k (blood sugar check)			regards to protocol paramete	ers	
		before meals and at			for MD notification of		
		eall the physician if the			hypo/hyperglycema events v documentation in clinical rec		
	blood sugar was	less than 60 or more than			of this notification. Education		
	400.				be ongoing and during		
					orientation. Nursing staff will	be in	
	The resident's N	urses' Notes, dated			serviced by, 8.31.11.		
		a.m., indicated the			4. Quality Assurance		
		sugar was 52 and orange			100% audit weekly X 4 wee	ks of	
		and after 15 minutes the			accu check results then		
	1 "				monthly X 6 months.		
	blood sugar was	/4.			Continued need for audit w		
					be determined thru PI proce if greater then 95 % compli		
		of documentation in the			noted at 6 months. Nursing		
	resident's Nurses	s' Notes and MAR to			administration will review		
	indicate the resid	dent's physician had been			resident's with change of		
	notified of the lo	ow blood sugars.			condition ongoing during t	he	
		2			clinical meeting, held Mond		
	 During an interv	riew on 08/02/11 at 10			thru Friday during business	•	
	I -	dicated the physician had			hours, to ensure proper MD)	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/08/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 1309 E	DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	not been notified She indicated the in the resident's r Units 24 hour represident's physicial 2. Resident #24' 08/02/11 at 10:25 diagnosis included diabetes mellitus. The Physician's I dated 08/11, indiwritten on 03/08/resident's blood sand to notify the sugar was less the The resident's Mindicated the resident's Mindicated the resident a.m. on 07/12/11 blood sugar on 0. There was a lack MAR and in the the resident's phy of the low blood. During an intervirum, the Directo	of the low blood sugars. For was no documentation record or on the South port sheet to indicate the san had been notified. So record was reviewed on Soam. The resident's red, but was not limited to, seed, but was no			notification. Any non-compliance with physication found for resist receiving accu-checks the audits or during clinical meetings will be corrected immediately by notifying the physician and re-education provided as needed. 5. Systemic Change/Completion Date 8.31.11	dent' hru I he	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	li i	E SURVEY PLETED 2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN47978					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	Status", received Director of Nurs p.m., indicated, ' resident, his/her there is significa physical, mental There is a need t	ident's Condition or from the Assistant ing on 08/03/11 at 2:55 l'the facility will notify the attending physicianb. int change in the resident's or emotional statusd. or alter the resident's lications significantly"						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155287			08/08/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		ı	E GRACE ST	
DENCCE	LACD CADE CENT	·CD	l l	SELAER, IN47978	
RENSSE	LAER CARE CENT	EK	KEINS	SELAER, IN4/9/6	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225		ot employ individuals who			
SS=D	_	guilty of abusing, neglecting,			
		dents by a court of law; or			
		entered into the State			
		/ concerning abuse, neglect, sidents or misappropriation			
		and report any knowledge it			
		a court of law against an			
		would indicate unfitness for			
		aide or other facility staff to			
		de registry or licensing			
	authorities.				
	•	nsure that all alleged			
		g mistreatment, neglect, or			
		njuries of unknown source			
		ion of resident property are			
	•	ely to the administrator of other officials in accordance			
		ough established procedures			
		tate survey and certification			
	agency).	tate darvey and continuation			
	The facility must h	ave evidence that all			
	alleged violations	are thoroughly investigated,			
	•	further potential abuse while			
	the investigation is	s in progress.			
		nvestigations must be			
	· ·	ministrator or his designated			
	•	d to other officials in State law (including to the			
		certification agency) within 5			
	•	e incident, and if the alleged			
		I appropriate corrective			
	action must be tak				
		d review and interview,	F0225	F 2251. Corrective ActionC	NA# 08/31/2011
	the facility faile			1 was educated to the abuse	l l
	•	buse were reported		policy and appropriate notific procedure with corrective act	cation
	_	•			
	•	the Administrator for 1		applied on 7.25.11 by DON a	
	ot 4 allegations	of abuse reviewed, for		ED. Neither resident # 29 no	or#

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	LDING	00	COMPL	ETED	
		155287	B. WIN		-	08/08/2	011	
		l .	D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF 1	PROVIDER OR SUPPLIEF	8		1	GRACE ST			
RENSSE	LAER CARE CENT	ΓER			ELAER, IN47978			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	_	ID			(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE	
	2 of 3 residents	s reviewed for			30 were affected due to DON	1		
		abuse in a sample of			being notified immediately. 2.			
	22. (Resident	•			identification of others			
	ZZ. (Resident	#20 and #00)			potentially affected3. system			
	Findings includ	lo:			changesNursing staff to notif			
		ic.			and chart that the administra the facility has been notified			
	Davieus ef the	alla mation of mbusical			the allegation. Policy and	Oi		
		allegation of physical			Procedure for abuse was up	dated		
		7/22/11, on 8/3/11 at			to include Director of Nursing			
		licated CNA #1 made			Executive Director must be			
		hat CNA #2 was rough			notified immediately. Quarter	•		
		#29 and #30 while			reminder training of entire sta			
	providing peri	care. When the			the abuse and neglect policy reporting system will be	with		
	residents were	questioned, they did			conducted by social services			
	not confirm the	allegation. Resident			director/designee.Initial train			
	#29 did have a	bruise on her inner			by Social Services/SDC on t	-		
	thigh but appear	ared to be older.		abuse policy with new associates during orientation including				
	1 -	lid not have any						
	bruising.				recognizing abuse, perception			
					and proper reporting. Execut Director will manage suspec			
	Review of the	Witness Statements			abuse allegations immediate			
		(no time) indicated CNA			following state and facility	,		
		dent #29 and #30's			policies4. Quality			
		11 during the 3-11 shift			AssuranceAllegations will be			
		2 with incontinent care			reviewed in inter disciplinary			
		nts. CNA #1 indicated			meeting held Mon thru Fri. d business hours. Abuse repor	-		
					and follow up actions added	-		
		as rough when moving			monthly PI improvement			
	1	esident #30 while			meetings to monitor for trend	ls		
	'	ontinence care. CNA			and completeness5. System			
		ed at the time, that			Changes/Completion Date8.	31.11		
	while changing							
	1 ,	s roommate) she was						
	, ,, ,	gers into the resident's						
	1 -	e were finger marks.						
	The CNA also	indicated Resident #29						
	stated at the tir	me, that CNA #2 was						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	TE SURVEY IPLETED 8/2011	
	PROVIDER OR SUPPLIER		STREE 1309	T ADDRESS, CITY, STATE, ZIP COE E GRACE ST SSELAER, IN47978	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	statement from	h her. The witness CNA #1 indicated the dent occurred at shift				
	from CNA #2 daindicated that shounds at 9:30 do any walk thromidnight shift. That Resident # movement durith had informed the she had been he that she was avaindicated that she was not literview with the on 8/3/11 at 2:00 charge nurse he incident at 3:00 had made the all abuse. The Dirindicated at the call the Administ She indicated she arrived to we literally with the arrived to we literally with the arrived with the literally with the arrived with the she with the she was not literally with the arrived to we literally with the arrived to with the arrived with the literally with the arrived with the literally wit	ng last rounds and she ne midnight shift that having them all day so ware of it. She he did not say the way to the resident of rough at all. The Director of Nursing of p.m., indicated the had informed her of the ha.m., when CNA #1 hallegation of physical rector of Nursing time, that she did not estrator at that time. The informed the he next morning when				
	made aware of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE					
AND PLAN	OF CORRECTION	155287	A. BUIL			08/08/2	
		100207	B. WING		A PROPERTY OF ATTEMPT OF THE CORE	00/00/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GRACE ST		
RENSSE	LAER CARE CENT	ER			ELAER, IN47978		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTROL OF THE APPROPRIATE CONTR	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e arrived to work.					
	3.1-28(c)						
F0226 SS=D	written policies and mistreatment, negland misappropriation Based on record the facility failed and procedures reporting and mabuse related to informing the Adallegations of a assessing the mallegations of a of 4 allegations of a of 4 allegations of a 22. (Resident Findings included Review of the understanding allegations allegations of a personnel are many transfer of the supersonnel are many transfer of the super	dministrator of any buse and immediately esidents after buse were made for 1 of abuse reviewed, for reviewed for buse in a sample of ts #29 and #30) e: updated 2/09 Policy for ed abuse provided by or indicated all mandated to promptly ed resident abuse to their immediate	F0:	226	F 2261. Corrective Action CN 1 was educated To Abuse Powith appropriate notification procedure with corrective act applied on 7.25.11 by DON a ED. Resident #29's chart wa reviewed on 7.25.11 by DON ED. Head to toe assessment completed on 7/22/11 and in clinical record. Resident #30 chart was reviewed on 7.25. DON/ED. Head to toe assessment was completed 7/22/11 and in clinical record Identification of Others potentially affectedSince earesident could be at risk entirestaff was in serviced by SDC on 8.18.11 to proper notificat procedures in regards to alle abuse using our abuse policy state guidelines and how to conduct head to toe assessment or any resident immediately an allegation of abuse 3. Systemic changes Nursing sto notify the administrator immediately if allegation of a	olicy tion and s I and was 's 11 by on ch re /ED ion ged y and nents after	08/31/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155287		LDING	00	08/08/2	
		100207	B. WIN		DDDDGG GITH GTATE TIN GODE	00/00/2	011
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE GRACE ST		
RENSSE	LAER CARE CENT	FR			ELAER, IN47978		
				L			
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	
PREFIX TAG	representative an incident of r suspecting resimmediately re their immediate charge nurse immediately as offer medical a Findings of the treatment providocumented in record. When abuse is suspende reported to regardless of the incident occurr notifies the direct executive direct incident. Review of the abuse, dated 0 12:30 p.m., CN	the resident's medical an incident of resident ected, the incident must		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	e who se. use ector f f gnee. use uring zing er will wing ns n rs. p	DATE	
	residents were not confirm the #29 did have a thigh but appeared Resident #30 control bruising.	and #30 while care. When the questioned they did allegation. Resident bruise on her inner ared to be older. lid not have any Witness Statements (no time) indicated CNA			improvement meetings to mo for trends and completeness Systemic Change/Completi Date 8.31.11	5.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPL			E SURVEY PLETED
		155287	B. WING		- 08/08	/2011
NAME OF F	ROVIDER OR SUPPLIER		l	ET ADDRESS, CITY, STATE, ZIP CO	ODE	
RENSSE	LAER CARE CENT	ER		E GRACE ST SSELAER, IN47978		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
1710		dent #29 and #30's	ind			DATE
		1 during the 3-11 shift				
	. •	2 with incontinent care				
		nts. CNA #1 indicated				
		as rough when moving				
	_	esident #30 while ontinence care. CNA				
		ed at the time, that				
	while changing					
	(Resident #30's	s roommate) she was				
		ers into the resident's				
	_	e were finger marks.				
		ndicated Resident #29 ne, that CNA #2 was				
		th her. The witness				
		CNA #1 indicated the				
		dent occurred at shift				
	change.					
	Review of the V	Vitness Statement				
		ated 7/22/11 (no time)				
		he had started her				
		p.m., and she did not				
	•	ough rounds with the The CNA indicated				
		30 had a bowel				
	movement duri	ng last rounds and she				
		ne midnight shift that				
		naving them all day so				
	that she was av					
	indicated that s	the way to the resident				
	and she was no	_				
		 				
	The record for I	Resident #29 was				

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIER/CLIA (X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETE	ED
		155287	B. WIN			08/08/2011	ı
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				GRACE ST		
RENSSE	LAER CARE CENT	FR		1	SELAER, IN47978		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re Co	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		2/11 at 2:30 p.m.					
	Review of Nurs	ing Progress Notes					
	dated 7/22/11 a	at 10:15 a.m., indicated					
	a head to toe a	ssessment was					
	completed for t	he resident.					
	·						
	The record for I	Resident #30 was					
		2/11 at 1:20 p.m.					
		ing Progress Notes					
		at 1:00 p.m., indicated					
		•					
	nead to toe ass	sessment completed.					
	Intonvious with t	he Director of Nursing					
		he Director of Nursing					
		00 p.m., indicated the					
	_	ad informed her of the					
		a.m., when CNA #1					
	had made the a	allegation of physical					
	abuse. The Dir	rector of Nursing					
	indicated at the	time, that she did not					
	call the Adminis	strator at that time.					
	She indicated s	she informed the					
		ne next morning when					
		ork. Further interview					
		or of Nursing at the					
		•					
	time, indicated						
		both residents was					
	•	immediately as per the					
	abuse policy.						
		he Administrator on					
	•	o.m., indicated he was					
	made aware of	the incident on					
	7/22/11 when h	e arrived to work.					
	3.1-28(a)						

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155287	A. BUILDING B. WING		08/08/2011
	PROVIDER OR SUPPLIER		STREET A 1309 E	ADDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0246 SS=D	services in the fact accommodations of preferences, excell of the individual or endangered. Based on observate facility failed to delight was position could reach it and of 20 residents of placement in a sate #26) Findings included 1. Resident #26 8/2/11 at 9:10 a.r. light was not with was on the chair resident's bed. The resident was 8:25 a.m. He was call light was on the resident's bed reach. On 8/4/11 at 8:40 observed in bed.	right to reside and receive lity with reasonable of individual needs and of when the health or safety other residents would be ation and interview, the ensure the resident's call need so that the resident dicall for assistance, for 1 oserved for call light imple of 22. (Resident hin reach. The call light that was next to the observed on 8/3/11 at a in bed. The resident's the chair that was next to i. It was not within his	F0246	F 157 1. Corrective action For resident 24 and 36 physicians were notified regarding low blood sugar Resident 24 had physician notified on Aug 2 nd, 2011 36 physician was notified 28 th, 2011, with documentation for both in regards to notification four the clinical record. 2. Identification of others potentially affected On August 19 th, 2011 a 100% was conducted for residents requaccu checks by nursing manage No resident found to require Minotification. Blood sugars within parameters. 3. Systemic changes	and July nd in audit quiring cment. D

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155287	A. BUILDING	00	COMPLETED 08/08/2011
		199267	B. WING		06/06/2011
NAME OF F	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE E GRACE ST	
RENSSE	LAER CARE CENT	FR		SSELAER, IN47978	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
		planket and the call		In service with education	
	,	ne side of the bed out of		provided to licensed nurse	es on
		ch. Interview with the		8.18.11 by staff developm	
		me indicated he did not		coordinator in regards to	
	know where the			protocol parameters for M	(D)
	Kilow where the	our right was.		notification of	
	Interview with I	PN #5 on 8/4/11 at 8:50		hypo/hyperglycema event	ts.
		e resident was capable of		with documentation in cli	
		ht. She indicated the		records of this notification	
	_	the call light to request		Education will be ongoing	
	assistance.	ne can right to request		during orientation. Nursir	-
	assistance.			staff will be in serviced b	<u> </u>
	3.1-3(v)(1)			8.31.11.	,
	3.1 3(1)(1)			0.51.11.	
				4. Quality Assurance	
				100% audit weekly X 4 w	veeks
				of accu check results then	
				monthly X 6 months.	
				Continued need for audit	will
				be determined thru PI pro	
				if greater then 95 %	
				compliance noted at 6 mg	onths
				Nursing administration w	I
				review resident's with cha	
				of condition ongoing duri	·
				the clinical meeting, held	-
				Monday thru Friday durir	
				business hours, to ensure	
				proper MD notification. A	Anv
				non-compliance with	
				physician notification fou	nd
				for resident's receiving	
				accu-checks thru audits o	r
				during clinical meetings v	
					,

OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(AZ) MOLITI	LE CON	ISTRUCTION 00	(X3) DATE : COMPI	
or condition	155287		3		08/08/2	
		STR	09 E G	GRACE ST		
		ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
· `				CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
				·	-	
				5. Systemic Change/Completion Date		
maintenance servi	ces necessary to maintain			8.31.11		
facility failed to denvironment was related to marred chipped paint, midbaseboard rail, and of 4 units and 1 chad the potential residents residing Unit, Special Car Unit and North E Findings included The following was Environmental To On the West Unit	ensure the resident's clean and in good repair and gouged doors, issing floor tiles, broken and blistered plaster for 4 of 3 dining rooms. This to affect 107 of the 107 g in the facility. (East re Unit, South Unit, West Dining Room) as observed during the our on 8/4/11:	F0253		Corrective Action Room 407 had door immedia painted, room 414 had chipp paint immediately fixed, show room door and tile for West had were immediately fixed, room had marred door painted. So halls shower room had marred door fixed. Special care unit baseboard was immediately Room 113 had marred door immediately fixed. North dinn room wall, below window, ha work completed immediately. Orders were initiated on 8.4. and work completed. Identification of others potentially affected. 100% audit concerning environmental rounds in regat to paint and tile was conduction 8.12.11 by maintenance supervisor and assistant.	ed ver nall n 301 uth ed fixed. ning d . 11	08/31/2011
	The facility must p maintenance servi a sanitary, orderly. Based on observa facility failed to denvironment was related to marred chipped paint, must baseboard rail, and of 4 units and 1 chad the potential residents residing Unit, Special Car Unit and North E. Findings included The following was Environmental To On the West Unit		The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred and gouged doors, chipped paint, missing floor tiles, broken baseboard rail, and blistered plaster for 4 of 4 units and 1 of 3 dining rooms. This had the potential to affect 107 of the 107 residents residing in the facility. (East Unit, Special Care Unit, South Unit, West Unit and North Dining Room) Findings include: The following was observed during the Environmental Tour on 8/4/11: On the West Unit at 10:30 a.m.:	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred and gouged doors, chipped paint, missing floor tiles, broken baseboard rail, and blistered plaster for 4 of 4 units and 1 of 3 dining rooms. This had the potential to affect 107 of the 107 residents residing in the facility. (East Unit, Special Care Unit, South Unit, West Unit and North Dining Room) Findings include: The following was observed during the Environmental Tour on 8/4/11: On the West Unit at 10:30 a.m.:	PROVIDER OR SUPPLIER ELAER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred and gouged doors, chipped paint, missing floor tiles, broken baseboard rail, and blistered plaster for 4 of 4 units and 1 of 3 dining rooms. This had the potential to affect 107 of the 107 residents residing in the facility. (East Unit, Special Care Unit, South Unit, West Unit and North Dining Room) Findings include: The following was observed during the Environmental Tour on 8/4/11: On the West Unit at 10:30 a.m.: SIRRETADRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN47978 STREETADRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN47978 STREETADRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN47978 STREETADRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN47978 STREETADRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN47978 SUMMARY STATEMENT OF CRESCION. PREFIX TAG BROUNDES HAND TO CRESCIDENT CROSS-REFERENCE CORESTER. BROUNDES HAND TO CRESCIDENT CROSS-REFERENCE CORESTER. PREFIX TAG BROUNDES HAND TO CRESCIDENT CROSS-REFERENCE CORESTER. BROUNDES HAND TO CRESCIDENT CROSS-REFERENCE TO RESCIDENT CROSS-REFERENCE	ROUTDER OR SUPPLIER ELAER CARE CENTER SUMMARY STATEMENT OF DEFICUENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred and gouged doors, enlipped paint, missing floor tiles, broken baseboard rail, and blistered plaster for 4 of 4 units and 1 of 3 dining rooms. This had the potential to affect 107 of the 107 residents residing in the facility. (East Unit, Special Care Unit, South Unit, West Unit and North Dining Room) Findings include: The following was observed during the Environmental Tour on 8/4/11: Deach 407 be blicked as a successory of the properties of the potential to affect 107 of the 107 or the West Unit at 10:30 a.m.: A Brown 407 be blicked as a successory of the properties of the potential to affect 107 of the 107 or the West Unit at 10:30 a.m.: A Brown 407 be blicked as a successory of the properties of

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND TEAN	or condition	155287		LDING	00	08/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	GRACE ST		
RENSSE	LAER CARE CENT	ΓER		1	ELAER, IN47978		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG			+	IAG	·	audit	DATE
	the bottom 18 inches of the closet door. Interview with the Housekeeping				Mentioned areas placed on audit form and maintenance will round		
		e time of tour, indicated 2			on indicated areas 1X per we	eek	
	_				for 12 weeks. With forms monitored by		
	persons resided in the room.				Executive Director		
	b. Room 414 had chipped paint on the wall, 18 inches from the floor, between the bathroom and the closet door.				Quality Assurance		
					Maintenance to do environm		
					rounds monthly and present the PI committee. PI commit		
		ne Housekeeping			determine if rounding should		
	Supervisor at the time of tour, indicated 1 person resided in the room.				continue if after 2 quarters of		
					100% compliance has occur	red.	
					Systemic change/completion	n	
	c. The door to th	e shower room had			date		
	gouges on the do	oor edge and the					
	kickplate. There	were 8 missing tiles on					
	the shower room	floor. Interview with the					
	Housekeeping S	upervisor on 8/4/11 at					
	11:45 a.m., indic	eated 26 resident used the					
	West Unit showe	er room.					
	On the South Un	nit at 10:50 a.m.:					
	a. Room 301 had	d black marred areas on					
	the bottom 18 in	ches of the door					
	kickplate. Interv						
		upervisor at the time of					
	tour, indicated 2	persons resided in the					
	room.						
	b. The door to th	e shower room had black					
	marred areas on	the kickplate. Interview					
	with the Housek	eeping Supervisor on					
	8/4/11 at 11:45 a	.m., indicated 31 persons					
	resided on the So	outh Unit and used the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		A. BUILDING		NSTRUCTION 00	(X3) DATE S COMPL 08/08/2	ETED	
	PROVIDER OR SUPPLIER		13	09 E (DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	shower room.						
	On the Special C	are Unit at 11:00 a.m.:					
	baseboard outsid Interview with th Supervisor on 8/4	4/11 at 11:45 a.m., ons resided on the t.					
	the kickplate of t the Housekeepin	black marred areas on he door. Interview with g Supervisor at the time 2 persons resided in the					
	11:40 a.m. A 15 is below the windown blistered and in mas 6 inches abowith the Houseke time of tour, indi	g Room was observed at foot area of the wall w had plaster that was need of repair. The area ve the floor. Interview reping Supervisor at the cated 32 residents ate a North Dining Room.					
	_	4/11 at the time of the l the above areas were in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/08/2	ETED	
	PROVIDER OR SUPPLIER			1309 E	DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=E	facility must be proin accordance with plan of care. Based on obse and interview, the ensure physicial resident's current followed related wheelchair sensugars, blood is supplements, the sores, daily well medication admicompleted, and reduction reconsumed to the supplements of t	sory pad alarms, blood ugar protocol, dietary reatments for pressure ights completed, ninistration, labs gradual dose nmendations for 8 of idents reviewed for s. (Residents #2, #4, #36, #41, and #49) e: 9:10 a.m., Resident red sitting on the side ing breakfast. At that no bed alarm	F0	282	F282 483.20(k)(3)(ii) Service By Qualified Persons/Per C Plan 1. Corrective action at Resident #41, this resident nonger resides in this facility. Resident #49, fall intervention were reviewed on 8/19/11 and be monitored as needed c. Resident #19, the physician notified on 8/4/11 and new or received to change blood sugmonitoring protocols to prima physician protocols. d. Resider, the physician was notified 8/2/11 and new orders receive continue with Glucerna 3 time day. The Yogurt order was clarified with the dietary department on 8/3/11 and is on the resident's tray card ar served with meals. e. Resider, the dressing to left inner was applied on 8/2/11 in fron surveyor f. Resident #2, the physician reviewed the resident medical record and declines this time to proceed with decrease in anti-anxiety medication on 8/3/11. The physician reviewed resident weights and current orders a discontinued the daily weight and I.M. Lasix on 8/3/11 due resident weight stable. g.	are o b. ns nd will was rders gar ary dent d on red to es a now ad ent r heel t of ent's at	08/31/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155287 08/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1309 E GRACE ST RENSSELAER CARE CENTER RENSSELAER, IN47978 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE stroke, and diabetic neuropathy. The Resident #36, the physician was notified of resident blood sugars resident was admitted to the facility on 7/28/11 with no new orders, on 7/16/11 from the hospital. with documentation in clinical record h. Resident #2. resident Review of Physician orders dated no longer resides in this facility. 7/19/11 indicated sensory pad alarm 2. Identification of others potentially affected deficient to bed and wheelchair. Check practice. On August 19 th. 2011. placement and function every shift. 100% audit was conducted by the DON/Unit Managers for residents The current plan of care dated with (a) safety devices, (b) blood 7/25/11 indicated the resident had a sugar checks, (c) wound dressings, (d) pharmacy history of multiple falls. The nursing recommendations, and daily intervention was to place a sensor weights. . On August 15 th , pad alarm to bed and wheelchair. 2011, 100% audit was conducted by the Dietary Manager/DON for residents receiving a nutritional Review of Nursing Progress Notes supplements. At this time the dated 7/29/11 at 1:00 a.m., indicated facility is in compliance with the the resident was found lying on the above. 3. systemic changes On floor in front of the bathroom door. August 18, 2011, In-Service was conducted for nursing staff. Dietary Manager and SSD by Review of the Incident Follow up and Staff Development Coordinator Recommendations Form provided by regarding physician notification, the Assistant Director of Nursing blood sugar monitoring, daily (ADON) on 8/3/11, indicated CNA #3 weights, nutritional supplements, answered the call light in Resident wound care, and pharmacy consultant reports, safety devices 41's room. The resident's roommate and how to document in clinical had turned the call light on for her. record. 4. Quality Assurance The resident had gotten out of bed to Nursing Administration will walk to the rest room and had fallen. monitor residents who receive The resident had a personal alarm on accu checks, daily weights, wound dressings, along with her bed that was not clipped to her nursing administration, the dietary night gown. manager/designee will audit nutritional supplements by Review of Nursing Progress Notes observing 3 meals per week x 4 dated 8/1/11 at 7:45 a.m., indicated weeks then 3 meals per month x

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155287	B. WIN			08/08/20	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	GRACE ST		
RENSSE	LAER CARE CENT	FR		1	ELAER, IN47978		
						-	(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
IAG			+	IAG	6 months. Need for audits to		DATE
		as found on the floor by			continue will be determined t	hru	
	the bathroom doorway.				PI process if <100% complia		
					is noted at 6 months. Monitor	ring	
		ncident Follow up and			will be to see if physicians we	ere	
		ion Form provided by			notified for any parameters	.	
		3/3/11 indicated CNA #4			outside prescribed order. Fal		
		acility at 4:00 a.m., she			intervention devices in place Weights obtained as ordered		
		report. After that, she			Nutritional supplements give		
	answered Resi	dent 41's call light.			ordered on tray cards. Call li		
	The resident's	roommate had placed			Rounding will be conducted		
	the call light on for the resident. She entered the room to find Resident 41 on the floor. The immediate action				per shift x 4 weeks. Then 2x		
					week x 4 weeks, then month		
					months then quarterly until 1 compliance is attained and	00%	
	put into place a	at that time was a bed			maintained x2 quarters. Unit		
	alarm was plac	ed on the bed.			managers to monitor roundin		
					schedule. The SSD will audi	t in	
	Interview with t	he West Unit Manager			behavior meeting pharmacy		
	on 8/3/11 at 1:0	00 p.m., indicated the			consultant reports x 4 weeks monthly x 6 months. PI	tnen	
	resident did no	t have a sensory pad			committee to determine if		
	alarm to her be	ed at the time of both			rounding should continue after	er 2	
	falls. The Wes	t Unit Manager			nd quarter if 100% compliand		
		larm box the resident			has occurred 5. Systemic		
		eelchair and the one on			change/completion date		
		wo different types of					
		arm box on her bed					
		n not a sensory pad					
	· ·	so indicated at the time,					
		g care of the resident					
		e to check to make					
	•	et alarms were in place.					
		adinio word in piace.					
	Review of Phys	sician Orders dated					
	1						
		ed a Complete Blood					
		asic Metabolic Panel					
	weekly times th	ree weeks then					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155287	A. BUI	LDING	00	COMPL 08/08/2	
		100207	B. WIN	_		06/06/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RENSSE	LAER CARE CENT	FR		1	GRACE ST ELAER, IN47978		
							715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ew of the Laboratory	<u> </u>				
	•	ed the Complete Blood					
		Basic Metabolic Panel					
	were completed weekly for three						
	weeks. Interview with the West Unit Manager						
		30 p.m., indicated					
	_	d not complete a					
	requisition for the	he labs to be					
	completed.						
		t 2:45 p.m., Resident					
		ved sitting in her room by her bed. At that					
	time, there was	-					
	•	e side of the chair and					
	it was turned or						
	The record for I	Resident #49 was					
	reviewed on 8/4	4/11 at 10:55 a.m. The					
	resident's diagr	noses included, but					
	were not limited	d to, heart failure and					
	dementia.						
	•	sician Orders dated					
		ed sensory pad alarm					
		ionary chair. Another					
	Physician order						
		ory pad alarm to					
	wheelchair.						
	Nursing Progra	ss Notes dated 7/7/11					
	at 12:15 p.m., i	ss Notes dated 7/7/11					
	-	ound the resident lying					
	Tionseveehel ic	ond the resident lying					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155287		LDING	00	08/08/2011
		100201	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2011
NAME OF P	PROVIDER OR SUPPLIER			1	GRACE ST	
RENSSE	LAER CARE CENT	ER		1	ELAER, IN47978	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ront of her wheelchair				
	next to her bed.					
	Review of the Incident Follow up and Recommendation Form indicated the					
		und on the floor next				
		e resident stated she				
		wheelchair onto the				
	floor. The pull					
	-	ne sensor pad was				
	unplugged.					
	- - 55					
	Interview with t	he Director of Nursing				
	on 8/5/11 at 9:1	0 a.m., indicated the				
	resident's alarn	ns should have been				
	attached to the	resident and plugged				
	in.					
	3. The record for	Resident #19 was				
	reviewed on 8/4/	11 at 8:55 a.m. The				
	resident had diag	noses that included, but				
	were not limited	to, diabetes, dementia				
	and hypertension	l.				
		nysician Order Sheet was				
		sician order, dated				
	•	d to check and record the				
		sugar four times a day. A				
		dated 6/29/10, indicated				
		ord blood sugar as				
		sugar is less than 70, give				
		r orange juice and				
	recheck in one ho	our.				
	Review of the Ju	ly 2011 Medication				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED (2011	
	PROVIDER OR SUPPLIEF		1309 E	ADDRESS, CITY, STATE, ZIP C GRACE ST SELAER, IN47978	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		ecord indicated the sugar readings were as				
	7/1/11 at 7:30 a.ı	m. = 61				
	7/2/11 at 7:30 a.1	m. = 69				
	7/5/11 at 7:30 a.1	m. = 69				
	7/11/11 at 7:30 a	m = 68				
	7/12/11 at 7:30 a	.m. = 69				
	7/13/11 at 7:30 a	m. = 68				
	7/17/11 at 7:30 a	.m. = 69				
	7/18/11 at 7:30 a	.m. = 62				
	7/21/11 at 7:30 a	.m. = 66				
	7/31/11 at 7:30 a	.m. = 68				
	dated 7/1/11 throof the July 2011 Administration I resident did not i juice when his balance.	Medication Record indicated the receive a glass of milk or lood sugar was below 70. It's blood sugar was not be hour as ordered by the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/08/2011	
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP CODE GRACE ST SELAER, IN47978	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	p.m., indicated th	PN #3 on 8/4/11 at 1:25 ne physician's order was en the resident's blood 70.			
		was observed on 8/1/11 at g lunch. The resident was t.			
		observed during the 8/1/11 at 6:05 p.m. She ogurt.			
	Interview with LPN #3 on 8/1/11 at 6:05 p.m., indicated the resident did not have yogurt with her dinner meal. The resident was observed on 8/3/11 at breakfast. The resident did not have yogurt with her breakfast.				
	8/3/11 at 9:40 a.r	ny card was reviewed on m. There were no oviding yogurt with the me tray card.			
	on 8/2/11 at 10:5 physician's order three times daily dated 4/25/11 ha	esident #4 was reviewed 5 a.m. There was a dated 6/22/11 for yogurt. The nutritional care plan d an intervention that ident was to receive as per day.			
	directions for promeals listed on the The record for R on 8/2/11 at 10:5 physician's order three times daily dated 4/25/11 had indicated the resident the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated the resident three times daily dated 4/25/11 had indicated three times daily dated 4/25/11 had ind	esident #4 was reviewed 5 a.m. There was a dated 6/22/11 for yogurt The nutritional care plan d an intervention that			

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE S COMPLI 08/08/20	ETED	
		100207	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/20	
NAME OF I	PROVIDER OR SUPPLIE	R		1	GRACE ST		
RENSSE	ELAER CARE CENT	ER		1	ELAER, IN47978		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
IAU	<u> </u>	erviewed on 8/2/11 at 2:45	+	IAU	,		DATE
		ed she administered					
	Glucerna (a liquid dietary supplement) to						
	` *	dietary supplement. She					
	indicated she did not administer yogurt.						
	Interview with the Dietary Manager on 8/3/11 at 2:30 p.m., indicated she had not						
	1	for the resident at meal					
	times or in between the meals, three times						
	per day, as ordered by the physician.						
	5. Resident #26	was observed in bed on					
	8/2/11 at 2:40 p.:	m. There was no dressing					
	observed on the	resident's left inner heel.					
	Observation of t	he resident's left inner					
	heel indicated th	ere was a pressure ulcer.					
	Interview with the	ne Assistant Director of					
		time, indicated the					
	_	ressure ulcer on his left					
	_	as no dressing in place on					
		er. The Assistant Director					
	1 ^	ated there had been a					
	1	the area and the blister					
	had broken. She	indicated the ulcer was 1					
	x 1.4 centimeters	s in size. The area was					
	dark red in color						
		esident #26 was reviewed					
		a.m. An entry in the					
	1 01 0	notes dated, 7/28/11 at					
	_	ited, "Rec'd (received)					
	new order to L (left) lat (lateral) heel,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MUL: A. BUILDI B. WING		00	(X3) DATE S COMPL 08/08/2	ETED	
	PROVIDER OR SUPPLIER			1309 E (DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	where Res (resid 1.7 x 0.8, reddish closed, no edema Rec'd new order dressing used for ulcers)"	ent) has soft blood blister a/purple in color, edges a, no c/o (complaint) pain, for Duoderm (a type of the treatment of pressure					
	Record" was reviews a deep tissue heel, first noted o	Pressure Ulcer Status lewed. It indicated there injury on the left inner on 2/27/11. The areas was eters) in size and was					
	p.m., indicated, "inner heel blood	r, dated 7/28/11 at 2:00 Apply Duoderm to left blister. Change q (every) as needed) for soilage or 4 days."					
	administration R Duoderm was ap heel on 7/28/11. documentation th	ly 2011 Treatment ecord indicated the plied to the left inner There was no ne Duoderm was applied neel after 7/28/11.					
	p.m., who was the Resident #26 for indicated she was to the resident's placed heel was not in p	PN #2 on 8/2/11 at 2:45 e nurse in charge of the day shift on 8/2/11, s not aware the dressing pressure ulcer on his left lace. She indicated the received a shower that					

B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZII	P CODE
RENSSELAER CARE CENTER 1309 E GRACE ST RENSSELAER, IN47978	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TIC CROSS-REFERENCED TO TIC DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE
day.	
Interview with the Assistant Director of Nursing on 8/2/11 at 2:50 p.m. indicated the last time the dressing was documented as applied to the resident's pressure ulcer was on 7/28/11. She also indicated the resident did not have a dressing in place as ordered by the physician when observed on 8/2/11 at 2:40 p.m. She indicated the dressing was to be changed every 3 days. 6. The record for Resident #2 was reviewed on 8/2/11 at 10:30 a.m. The resident had diagnoses that included, but were not limited to, hypertension, anxiety, and congestive heart failure. The Pharmacy Consultant Report, with a recommendation date of 5/23/11, was reviewed. The report indicated the resident had received alprazolam (an anti-anxiety medication) 0.75 mg (milligrams) every night since January 1, 2011 for anxiety. The recommendation indicated a gradual dose reduction, perhaps decreasing the medication to alprazolam 0.5 mg every night. The attending physician indicated he accepted the recommendation. He indicated the decreased dose was to be implemented as written.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/08/2	ETED	
	PROVIDER OR SUPPLIER		B. WIW	STREET A 1309 E	DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978		
					ELAER, IN4/9/0		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	Review of the Ju 2011 Medication indicated the res (trade name for a every night. Review of the modated 5/25/11 the there was no door physician's order recommendation Pharmacist, to do was followed. Interview with the Designee on 8/3 indicated she was physician's agree resident's dose of indicated the physician's agree resident's dose of indicated the physician of the Physician Offor Resident #2 dated 6/4/11, indicated was to be adminificated than 2 pounds.	ane 2011 and the July a Administration Records ident received Xanax alprazolam) 0.75 mg arsing progress notes rough 8/2/11 indicated cumentation the atto implement the		TAG	DEPICIENCY)		DATE
		ough 8/2/11, the June					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SM4M11 Facility ID:

000185

If continuation sheet

Page 28 of 55

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155287	B. WIN			08/08/2	011
		l	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	₹			GRACE ST		
RENSSE	ELAER CARE CENT	TER		1	ELAER, IN47978		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,		(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	2011 and July 20						Dille
	1	Records, and the resident's					
	~	ndicated the resident was					
	not weighed daily as ordered by the						
	physician.						
	Danies Cul	alahi ah asi la di cerat					
		eight sheet indicated					
		eights obtained on					
	1	, 6/27/11, 6/30/11, 7/1/11,					
	1 ' '	/5/11, 7/6/11, 7/17/11,					
	and 7/18/11.						
	The state of	/0/11					
	The weight on 6/9/11 was recorded as						
	1	t on 6/8/11 was 179.8, a					
	2.4 pound weigh	•					
	1	/13/11 was recorded as					
	'	on 6/12/11 was 168, a 4					
	pound weight ga	in.					
	The weight on 6	/25/11 was recorded as					
		t recorded on 6/24/11 was					
	151.1, a 8.1 pou	ınd weight gain.					
	The weight on 7	/14/11 was recorded as					
	158.6 , the weigh	ht recorded on 7/13/11					
	1	pound weight gain.					
	The June 2011 a	nd July 2011 Medication					
	Administration I	Records were reviewed.					
	Lasix 40 mg was	s not administered on					
	6/9/11, 6/13/11,	6/25/11, and 7/14/11 for					
	the weight gains	that were greater than 2					
	pounds, as order	ed by the physician.					
	Interview with the	ne Assistant Director of					
	Nursing on 8/4/1	11 at 1:30 p.m. indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/08/2011			LETED	
	PROVIDER OR SUPPLIER		B. WIN	1309 E	DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978	357007	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	ordered by the plindicated the Lass for the 2 pound we by the physician. 7. Resident #36 on 08/01/11 at 4 diagnoses include to, diabetes mellion. The Physician's India diagnoses included to a diabetes mellion. The Physician's India diagnoses included to a diabetes mellion. The Physician's India diagnoses included to a diabetes mellion. The Physician's India diagnoses included to a diabetes mellion of the Physician's India diagnoses included to a diagnose	I's record was reviewed p.m. The resident's ed, but were not limited tus and hypertension. Recapitulation Orders, cated an order, which 16/11, to administer a comparent (blood sugar check) before meals and at all the physician if the cless than 60 or more than do 06/17/11, indicated the cless for low blood sugars. Indicated, "monitor accuchecks (glucometer) otify md as needed" In the properties of the comparent of the cless of the comparent of the cless of the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155287	A. BUI	LDING	00	08/08/20	
		155267	B. WIN			06/06/20	711
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DENIGOE	LAER CARE CENT	ED		1	GRACE ST ELAER, IN47978		
					ELAEN, IN47976		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
1710	notified of the lo			1710	·		DATE
	notified of the fo	w blood sugars.					
	During on intervi	iew on 08/02/11 at 10					
	~	licated the physician had					
	· ·	of the low blood sugars.					
		ere was no documentation					
		record or on the South					
		oort sheet to indicate the					
	1	ian had been notified.					
	l resident's physici	ian nau ocen nouneu.					
	A care plan date	d 07/28/11, indicated the					
	1 1	etes. The approaches					
		tor accuchecks per md					
	· ·	•					
	orderskeep md						
	indicatednotily	md as needed"					
	The Physician's I	Recapitulation Orders,					
	1 *	cated an order, originally					
	written on 03/08/						
		sugar three times a day					
		physician if the blood					
		an 60 or more than 400.					
	54541 Was 1035 til	wii oo oi more mun 100.					
	The resident's M.	AR dated 07/11					
		dent's blood sugar at 7					
		was 48 and the 7 a.m.					
	blood sugar on 0						
	oroca sagar on o	,,_0,11 114007.					
	There was a lack	of documentation on the					
		Nurses' Notes to indicate					
		vsician had been notified					
	of the low blood						
	of the low blood	545 ⁴¹ 5.					
	During an intervi	iew on 08/02/11 at 1:50					
	·						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155287	A. BUI	LDING	00	COMPL 08/08/2	
		100207	B. WIN			00/00/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
RENSSE	LAER CARE CENT	FR		1	GRACE ST ELAER, IN47978		
					ELINEN, INVITOTO		(1/5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		r of Nursing indicated the					
	physician had not been notified of the low blood sugars.						
	 8 Resident #24'	s record was reviewed on					
		5 a.m. The resident's					
		ed, but were not limited					
	to, diabetes melli						
	to, diabetes mem	itus.					
	A care plan date	d 07/28/11, indicated the					
		petes. The approaches					
	indicated, "mo	* *					
	ordersnotify m	•					
	ordersnothly in	u as needed					
	The Dhycician's I	Recapitulation Orders,					
	1 *	cated an order, originally					
	written on 03/08/						
		sugar three times a day					
	l -	physician if the blood					
	sugai was iess in	an 60 or more than 400.					
	The resident's M	AR dated 07/11					
		ident's blood sugar at 7					
		was 48 and the 7 a.m.					
	blood sugar on 0	//20/11 was 3/.					
	There was a lack	of documentation on the					
		Nurses' Notes to indicate					
		ysician had been notified					
	of the low blood						
	of the low blood	sugais.					
	During an intervi	iew on 08/02/11 at 1:50					
	~	r of Nursing indicated the					
	_	t been notified of the low					
	pirysician nau no	t occii notifica di tile idw					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 08/08/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	1309 E	DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
F0314 SS=D	a resident, the fac resident who enter pressure sores do sores unless the ir demonstrates that a resident having	prehensive assessment of lility must ensure that a rs the facility without es not develop pressure adividual's clinical condition they were unavoidable; and pressure sores receives					
	necessary treatments healing, prevent in sores from develor Based on observating interview, the factories as ordered by the	ent and services to promote effection and prevent new ping. ation, record review and eality failed to ensure eatments were provided a physician for 1 of 3 pressure ulcer in a sample #26)	F0	F314 483.25(c) Treatment/SVCS To Prevent/Heal Pressure Sores 1. Corrective action Resident #26, dressing applied in front of surveyor 8/2/11 and healed out on 8.11.11 2. Identification of others. On August 19 th 2011 a 100% audit was conducted by the		#26, out on 1 a y the	08/31/2011
	8/2/11 at 2:40 p.1 observed on the r A pressure ulcer resident's left inn	s observed in bed on m. There was no dressing resident's left inner heel. was observed on the er heel. de Assistant Director of	Residents were Dressing in pla changes On Ai In-Service was nursing staff re care dressings development of Quality Assura		requiring wound care dressin Residents were found to have Dressing in place 3. system changes On August 18, 2012 In-Service was conducted for nursing staff regarding wound care dressings by staff development coordinator. 4. Quality Assurance 100% au	gs. e ic I,	
	Nursing, at that t resident had a pro- heel and there wa the pressure ulce	ime, indicated the essure ulcer on his left as no dressing in place on r. The Assistant Director ated there had been a			to monitor for residents who require wound dressing chan according to physician orders be utilized weekly x 6 months DON, nursing management, designee. Any non-compliant will be immediately addresse	s will s by or ce	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155287		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/08/2	ETED	
	PROVIDER OR SUPPLIEF		•	1309 E	DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978		
	SUMMARY S (EACH DEFICIEN REGULATORY OR blood blister on had broken. She x 1.4 centimeters dark red in color blister. The record for R on 8/2/11 at 9:30 diagnoses that in limited to, prosta cancer to the bra depression.	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) the area and the blister indicated the area was 1 s in size. The area was r; it was a ruptured blood desident #26 was reviewed a.m. The resident had acluded, but were not ate cancer, metastatic		1		is I be I will ee orders siness of	(X5) COMPLETION DATE
	"Rec'd (received (lateral) heel, wh soft blood blister in color, edges c (complaint) pain Duoderm (a type treatment of press." The form titled, Record" was rev was a deep tissue heel, first noted 1.7 x 0.8 (centim purple in color. A physician order p.m., indicated, inner heel blood	new order to L (left) lat here Res (resident) has r 1.7 x 0.8, reddish/purple losed, no edema, no c/o , Rec'd new order for e of dressing used for the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	I	E SURVEY PLETED /2011	
		100207	B. WING	ET ADDRESS, CITY, STATE, ZIP		12011
NAME OF F	PROVIDER OR SUPPLIER		ı	E GRACE ST	CODE	
RENSSE	LAER CARE CENT	ER	REN	SSELAER, IN47978		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
	dislodgement x 1	4 days."				
		ly 2011 Treatment				
		ecord indicated the				
	1	plied to the left inner				
	heel on 7/28/11.	ne Duoderm was applied				
		neel after 7/28/11.				
		1001 41101 //20/11.				
	Interview with L	PN #2 on 8/2/11 at 2:45				
	p.m., who was th	e nurse in charge of				
	Resident #26 for	the day shift on 8/2/11,				
	indicated she was	s not aware the dressing				
	· ·	pressure ulcer on his left				
	1	lace. She indicated the				
		received a shower that				
	day.					
	Interview with th	ne Assistant Director of				
		1 at 2:50 p.m. indicated				
	_	treatment for the pressure				
		ented as applied to the				
	resident's heel w	vas on 7/28/11. She also				
	indicated the resi	dent did not have a				
	Duoderm dressin	g in place on the				
	_	ordered by the physician				
		n 8/2/11 at 2:40 p.m. She				
		oderm dressing was to be				
	in place at all tim					
	changed every 3	days.				
	3.1-40(a)(2)					
	(%)(=)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155287	B. WIN			08/08/2011	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				GRACE ST		
	LAER CARE CENT	ER		l	SELAER, IN47978		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
			<u> </u>	TAG	DEFICIENCY)		DATE
F0323 SS=D	The facility must e environment remainazards as is possible receives adequated devices to prevent Based on obseinant interview, the ensure resident related to be discussed or function residents reviewed a larms in (Residents #41). On 8/2/11 at #41 was observed on the The record for I reviewed on 8/2 resident's diagray were not limited stroke, and dialogs.	nsure that the resident ins as free of accident sible; and each resident accidents. rvation, record review the facility failed to ts were free from falls and chair alarms not ning, for 2 of 15 wed with bed and/or the sample of 22. and #49) e: 1 9:10 a.m., Resident wed sitting on the side ng breakfast. At that is no bed alarm to bed. Resident #41 was 2/11 at 9:15 a.m. The noses included, but it to, history of falls, betic neuropathy. The idmitted to the facility	F0	323	F 323 483.25(h) Free of Accident Hazards/Supervision/Device 1. Corrective action accomplished for Resident affected by the alleged deficient practice: a. Resident #41, this resident no longer resides in this facility. b. Resident #49, fall intervention were reviewed and updated 8.19.2011 2. Identification of others potentially affected. August 19 th 2011 a 100% and was conducted by the DON/M Managers of residents require safety devices and residents devices applied per physicial order. 3 systemic changes In-Service was conducted for nursing staff regarding safety devices 8.18.11 by staff development coordinator. 4. Quality Assurance Safety Devices Rounding will be conducted 1x per shift x 6 me by licensed nurses and nursi assistants. Then quarterly un 100% compliance is attained	es dent ons on f On udit Jnit ing had n r r onths ng util and	08/31/2011
	7/19/11 indicate to bed and whe	sician orders dated ed sensory pad alarm eelchair. Check function every shift.			maintained x2 quarters. Unit managers to monitor roundin schedule.PI committee to determine if rounding should continue after 2 nd quarter of 100% compliance has occur 5. By what date the systemi	g f red	

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 08/08/2	LETED	
	PROVIDER OR SUPPLIEI			1309 E	ADDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE	
	Review of the is Set (MDS) assindicated the read was able to resident's vision. The resident's transfers, walk the toilet and so not steady. The used a wheelch ambulation. The history of falls to admit and in months. Review of the dated 7/16/11 was a high risk interventions a and wheelchair. The current pla 7/25/11 indicated history of multiplates intervention was a high risk intervention was a high risk intervention was an and wheelchair. The current pla 7/25/11 indicated history of multiplates intervention was pad alarm to be resident was floor in front of the Review of the Review of the Recommendate indicated the resident was floor in front of the Review of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the resident was floor in front of the Recommendate in the Re	essment dated 7/29/11 esident was understood o understand. The n was highly impaired. balance during ing, moving on and off urface to surface was he resident primarily hair and walker for he resident did have a in the last month prior the last two to six Fall Risk Assessment indicated the resident is for falls. The staff t that time, was a bed		IAU	changes will be completed Date of compliance 8.31.1		DATE

000185

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155287	B. WIN			08/08/2	011
		1	B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			GRACE ST		
RENSSE	ELAER CARE CENT	TER		1	SELAER, IN47978		
			_				ars)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
1710	-	· · · · · · · · · · · · · · · · · · ·	+	ino	· · · · · · · · · · · · · · · · · · ·		DATE
	, ,	3/11, indicated CNA #3					
	1	call light in Resident					
	41's room. The resident's roommate						
	had turned the call light on for her.						
		ad gotten out of bed to					
	walk to the res	t room and had fallen.					
	The resident h	ad a personal alarm on					
	her bed that wa	as not clipped to her					
	night gown.						
	Review of Nurs	sing Progress Notes					
	dated 8/1/11 at 7:45 a.m., indicated the resident was found on the floor by						
	the bathroom of	•					
	Review of the	Incident Follow up and					
		ion Form provided by					
		3/3/11 indicated CNA #4					
		acility at 4:00 a.m., she					
		report. After that, she					
		•					
		ident 41's call light.					
		roommate had placed					
	1	for the resident. She					
		om to find Resident 41					
		he immediate action					
	put into place a	at that time was a bed					
	alarm was place	ced on the bed.					
	Interview with	the West Unit Manager					
	on 8/3/11 at 1:0	00 p.m., indicated the					
		t have a sensory pad					
		ed at the time of both					
		t Unit Manager					
		larm box the resident					
		eelchair and the one on					
	Thad on her who	ceichail and the one on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAIN	OF CORRECTION	155287		LDING	00	08/08/2	
		100207	B. WIN	_	A DDDEGG CITY GTATE ZID CODE	00/00/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE GRACE ST		
RENSSE	LAER CARE CENT	ER		1	ELAER, IN47978		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	her bed were tw	vo different types of					
ı	alarms. The ala	arm box on her bed					
	was a clip alarm not a sensory pad alarm. She also indicated at the time,						
	the nurse taking	g care of the resident					
	was responsible	e to check to make					
	sure the correc	t alarms were in place.					
	0 0 000144	10.45 m ms Disetal 1					
		t 2:45 p.m., Resident					
		ved sitting in her room					
		by her bed. At that					
	time, there was an alarm box observed on the side of the chair and						
	it was turned or						
	it was tarried or	1.					
	The record for I	Resident #49 was					
	reviewed on 8/4	4/11 at 10:55 a.m. The					
	resident's diagr	noses included, but					
	were not limited	d to, heart failure and					
	dementia.						
		sician Orders dated					
		ed sensory pad alarm					
		ionary chair. Another					
	Physician order						
	wheelchair.	ory pad alarm to					
	wileciciali.						
	Review of the 5	5/24/11 quarterly MDS					
		dicated the resident					
	was understood						
	understand. Th	ne resident used a					
	walker and a w	heelchair primarily.					
	The resident ha	ad a history of falls					
	since prior asse	essment with no injury.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155287	A. BUII B. WIN			08/08/2	
NAME OF F	PROVIDER OR SUPPLIER		D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	LAER CARE CENT			1	GRACE ST ELAER, IN47978		
				ID	ELAER, IN47970		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	5/11 care plan is was a fall risk depisodes of dizinterventions with pad alarm to the chair. Review of the Fedated 6/24 and resident was a Nursing Progreat 12:15 p.m., in housekeeper for on the floor in finext to her bed. Review of the like Recommendation resident was for to her bed. The slid out of the wifloor. The pull attached and the unplugged. Interview with the on 8/5/11 at 9:1 resident's alarm.	ound the resident lying ront of her wheelchair ncident Follow up and on Form indicated the und on the floor next e resident stated she wheelchair onto the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155287 08/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1309 E GRACE ST RENSSELAER CARE CENTER RENSSELAER, IN47978 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3.1-45(a)(2) If specialized rehabilitative services such as, F0406 but not limited to, physical therapy. SS=D speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. F0406 08/31/2011 Based on record review and interview, the F 406 483.45(a) facility failed to ensure a speech therapy Provide/Obtain Specialized evaluation was completed as Rehab Services recommended for 1 of 22 residents reviewed for therapy in the sample of 22. 1. **Corrective action** (Resident #99) For resident #99: The physician was notified on Findings include: 8.22.11 with new orders to receive a speech evaluation. The record for Resident #99 was reviewed on 8/2/11 at 9:15 a.m. The resident's 2. Identify diagnoses included, but were not limited On August 19 th 2011 a 100% to, dysphasia (difficulty swallowing) and audit was conducted by aphasia (unable to speak). A physician's nursing management of order dated 8/2/10 and listed on the residents requiring therapy August 2011 Physician's Order Summary orders. At that time facility (POS), indicated the resident was was in compliance with orders receiving a mechanical soft diet. and recommendations A Rehabilitation Services A systemic change the Multidisciplinary Screening Tool dated facility has made to ensure 11/4/10, indicated a Speech Therapy the alleged deficient practice

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155287 08/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1309 E GRACE ST RENSSELAER CARE CENTER RENSSELAER, IN47978 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE evaluation was recommended for possible does not occur. diet change for upgrade to increase independence with activities of daily In-Service was conducted for living and increase quality of life. Based nursing staff regarding therapy on the evaluation, documentation communications 8.18.11. by indicated the resident may potentially staff development coordinator benefit from skilled therapy intervention Therapy department was to address deficits in speech-language in-serviced by Regional director of Therapy Services, pathology and an evaluation would be pursued with treatment orders. on 8.10.2011 There was no documentation available for 4. How corrective actions will review in the resident's record related to a be monitored to ensure that speech therapy evaluation. alleged deficient practice will not reoccur Interview with the Therapy Manager on 8/3/11 at 9:00 a.m., indicated a speech Nursing Administration will therapy evaluation had not been monitor therapy completed. recommendations daily thru a therapy folder in the Director 3.1-23(a)(1)of Nursing mailbox. Therapy will place requests for orders in a folder and the Director of Nursing/designee will retrieve requests daily and deliver to the Unit Managers each morning. Requests will be placed on a monitoring tool that will be reviewed during clinical meetings held M-F to see if orders are obtained and communicated to the therapy department. Monitoring will last x 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/08/2011		
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP CODE GRACE ST SELAER, IN47978	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE	ļ
				weeks. Then every 2 we weeks, then monthly x 3 months then quarterly u 100% compliance is atta and maintained x2 quar committee to determine monitoring should continue after quarter if 100% compliants occurred 5. By what date the systemages will be completed by the complete should be completed as a second should be completed by the complete should be	antil ained ters. PI if er 2 nd ance	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/08/2011			ETED	
	PROVIDER OR SUPPLIER			1309 E 0	DDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0431 SS=D	The facility must e of a licensed phan system of records all controlled druggenable an accurat determines that druggenable an account of maintained and permanently affixed of controlled druggenable. The facility must stream to be labeled in account of accepted profession the appropriate account of accepted profession the appropriate account of accepted profession the appropriate account of account of the facility must stream permanent of the permanent of the facility must permanently affixed of controlled druggenables. The facility must permanently affixed of controlled druggenables.	mploy or obtain the services macist who establishes a of receipt and disposition of is in sufficient detail to be reconciliation; and ug records are in order and all controlled drugs is priodically reconciled. Cals used in the facility must redance with currently onal principles, and include cessory and cautionary the expiration date when the state and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only nel to have access to the state of the rovide separately locked, and compartments for storage is listed in Schedule II of the rug Abuse Prevention and and other drugs subject to the distribution systems in					BAIL
	Based on observation interview, the factorized account maintained and ramount of Roxa (narcotic pain me	stored is minimal and a be readily detected. ation, record review, and cility failed to ensure an of a controlled drug was econciled, related to the nol (Morphine Sulfate) edication) signed as given the a resident was	F0	431	F 431 483.60(b), (d), (e) Dru Records, Label/Store Drugs Biologicals 1. Corrective action accomplished for Resident affected by the alleged deficient practice: Resident #109, the 2 nurses performing drug destruction if were educated by the DON of proper procedure for drug	s &	08/31/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155287	B. WING		08/08/2011
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER			GRACE ST	
RENSSE	LAER CARE CENT	ER		SELAER, IN47978	
				,	1 (7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA	TE DATE
IAG		· · · · · · · · · · · · · · · · · · ·	IAO	destruction and drug	DATE
		of 3 closed records		reconciliation on 8.19.11 2.	How
		nple of 22. (Resident		Facility reviewed all reside	
	#109)			who could be affected by t	
				same alleged deficient prac	I
	Findings include	:		A 100% audit was conducted	
				narcotics and narcotic record	ds.
	Resident #109's	closed record was		8.19.11, by the Pharmacy	
		03/11 at 10:40 a.m. The		Consultant and the facility is	in
		ses included, but were		compliance according to	
		· ·		pharmacy consultant review	
	1	mentia and anemia. The		systemic change the facilit has made to ensure the all	
record indicated the resident expired at			deficient practice does not	- 1	
	the facility on 06	/26/11.		occur. In-Service was condu	l l
				for Licensed Nurses regardi	
	A physician's ord	ler, dated 06/25/11,		Narcotic tracking and drug	
	indicated an orde	er for Roxanol, five		destruction. 8.19.11, by the	
		sublingually (SL) (under		Pharmacy Consultant. 4. He	ow
	1	hour as needed for pain		corrective actions will be	
	or respiratory dis	-		monitored to ensure that	
	or respiratory uis	ucss.		alleged deficient practice v	/III
		4 6 77 1		not reoccur Nursing Administration will monitor	
	A charge form from	•		Narcotic Drug Destruction.	
	, , ,	Kit (EDK) indicated a		Monitoring will be conducted	.
	30 milliliter (ml)	bottle of roxanol had		weekly to see if the amount	I
	been removed fro	om the facility's EDK on		drug dispositioned and the to	
	06/25/11.			amount of drug listed on the	
				narcotic count log. Weekly	
	The EDK control	lled substances kit listing,		monitoring will last for 4 wee	eKS
		anol bottle contained 20		and if 100% compliance is achieved be reduced to ever	rv
		I there was 30 ml in the		other week for 4 weeks, if 10	
		i mere was 30 mii m me		compliance is achieved be	
	bottle.			reduced to monthly x 4 mon	ths. If
				100% compliance is achieve	
		Administration Record		Performance Improvement	
	(MAR), dated 06	5/11, indicated the		Committee will review and d	l l
	resident should h	ave received 0.25 ml (5		if further monitoring is neces	· .
	mg) of the roxan	ol SL every hour as		5. By what date the systen	IIC

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI		
ANDILAN	or connection	155287	A. BUII		00	08/08/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	3			GRACE ST		
RENSSE	ELAER CARE CENT	TER .		I	ELAER, IN47978		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	needed for pain	or respiratory distress.			changes will be completed. Date of compliance 8.31.11		
	The MAR indica	ated the resident received					
	the 0.25 ml (5mg						
	5:45 p.m., 7 p.m	., 9:45 p.m., and 11:45					
	1 -	11 at 1 a.m. and 2 a.m.					
	1 ^	he total roxanol given					
		n 1.25 ml (35 mg).					
	The Individual F	Resident Control					
		ord Sheet, dated 06/25/11,					
		rting count of the roxanol					
	1	ere was 0.25 written					
		mount remaining and					
		written under the .25 mg.					
		te written on the amount					
	remaining. The						
		o indicate the resident had					
	received seven of	loses of the roxanol.					
	1 .	sition Form, dated					
	1	ned by two nurses,					
	indicated 19.75	mg was destroyed in the					
	facility (there sh	ould have been 565 mg or					
	28.25 ml left in	the bottle).					
	During an interv	iew on 08/03/11 at 1:30					
		ne of the nurses who					
		edication) indicated she					
	1	ntrolled medication					
		cated she thought there					
	1	bottle. She indicated the					
		igned out the roxanol and					
	1	v the nurses were					
	I THE STATE HO						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP	(X3) DATE SURVEY COMPLETED 08/08/2011	
	PROVIDER OR SUPPLIEF		STREET A 1309 E	ADDRESS, CITY, STATE, ZIP CO GRACE ST SELAER, IN47978	DDE	
RENSSE (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OR Counting the rox a.m., the Director she was in the property of the pro	tatement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) anol with shift change. iew on 08/05/11 at 9:55 or of Nursing indicated occess of investigating the anol. She indicated there epancy and was unable to the roxanol was because and a missing count sheet. In ourses who destroyed ad not measured the ication cup before edication. She indicated notified of the dated 01/15/09, titled,	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	3.1-25(m)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155287	B. WIN			08/08/2011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				GRACE ST	
RENSSE	LAER CARE CENT	FR			SELAER, IN47978	
						· · · · · · · · · · · · · · · · · · ·
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILIACI)	DATE
F0502		rovide or obtain laboratory ne needs of its residents.				
SS=D		onsible for the quality and				
timeliness of the services.						
•		review and interview, the	F0	502	F 502 483.75(j), (1)	08/31/2011
		obtain a stool specimen			Administration	
	_	2 residents reviewed for			1	
	,	aple of 22. (Resident #2)			1. Corrective action	
	laowork iii a saiii	ipic of 22. (Resident #2)			accomplished for Resider	
	F: 1: : 1 1				_ -	11
	Findings include	:			affected by the alleged	
					deficient practice:	
	The record for Resident #2 was reviewed					
	on 8/2/11 at 10:3	0 a.m. A physician's			a. Resident #2, Stool	
	order, dated 6/13	/11 at 4:30 p.m.,			specimen was obtained on	
	indicated to chec	k stools for C-difficile			6.17.11.	
	(clostridium diffi	cile a fungal infection				
	that causes diarrh	nea) x 3.			2. How Facility review	red
		,			all residents who could be	
	Review of the lab	poratory test results			affected by the same alleg	
		sample was collected on	1 -		deficient practice.	
		s after the physician's			deficient practice.	
	_	ol test was obtained. The			A 100% audit was complete	tad
		s positive for Clostridium			on 8.19.11 by the DON, of	
	•	•			· · · · · · · · · · · · · · · · · · ·	
		vsician was notified of the			residents with lab orders. A	7t
		8/11 and orders for			time of audit facility in	
	antibiotic treatme	ent were obtained.			compliance with lab orders	5
		rsing progress notes			3. A systemic change t	
		10:00 p.m. indicated, "			facility has made to ensu	re
	. loose stools x 4	this evening notified			the alleged deficient prac	tice
	(name of Physici	an) office at 4:30 p.m.			does not occur.	
	Rec'd (received)	n.o. (new order) to check				
	stool for C-diff x				In-Service was conducted	for
		-			Licensed Nurses regarding	I
						,

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/08/2011	
RENSSELA	OVIDER OR SUPPLIER AER CARE CENT	ER	P. WIN	STREET A 1309 E	ADDRESS, CITY, STATE, ZIP CODE GRACE ST ELAER, IN47978	1
F r s s	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) completing lab requisition and communicating lab or 8.18.11 by SDC 4. How corrective acti will be monitored to ensu that alleged deficient practice will not reoccur	is ders dons ure
S 6 S b	She indicated the 6/13/11, 6/14/11,	resident had stools on 6/15/11 and 6/16/11.			Nursing Administration we review new orders and lab order changes in change of condition. M-F lab orders be placed on a monitoring Monitoring will be conducted to see if orders are noted at placed on the lab communication log. Monitoring will last for 4 weeks and if 100% complies achieved be reduced to a times per week for 4 weeks 100% compliance is achieved to 1 time per weeks. If 100% compliance is achieved the Performance Improvement Committee will review and decide if further monitoring necessary. 5. By what date the system changes will be complete.	f will tool. eted and iance 3 as, if eved et t d ng is

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155287 08/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1309 E GRACE ST RENSSELAER CARE CENTER RENSSELAER, IN47978 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Date of compliance 8.31.11 The facility must maintain clinical records on F0514 each resident in accordance with accepted SS=E professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. F 514 483.75(I), (1) Based on record review and interview, the F0514 08/31/2011 Records-Complete/Accurate/Ac facility failed to maintain clinical records cessible 1. Corrective action that were complete and accurately accomplished for Resident documented related to clarification of affected by the alleged advance directive orders, clarification of deficient practice: a. Resident #75, the advanced directives medication parameters, dietary were clarified and corrected on supplements, clarification of treatment the resident's medical record on orders and documentation of medication 8.2.11 by the Social services administration for 5 of 22 residents Director b. Resident #4, the reviewed for clinical records in a sample physician was notified on 8.3.11 and new order obtained to of 22. (Residents #2, #4, #9, #26, and continue Glucerna three times a #75) day. c. Resident #26, .MD notified of podiatrist order and Findings include: was discontinued per primary physician due to resident on hospice and no need determined 1. The record for Resident #75 was at this time for anti-fungal reviewed on 8/2/11 at 10:50 a.m. The treatment on 8.2.11. d. Resident resident was admitted to the facility on #2, MD notified of eye drops were not documented on 6.29.11 & 4/9/11. At the time of admission, the 6.30.11. Resident eyes assessed resident had an advanced directive of "Do with no redness or complaints of not Resuscitate." irritation noted. No further orders on 8.18.11. e. Resident #9, MD

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SM4M11

Facility ID: 000185

If continuation sheet

Page 50 of 55

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155287	B. WIN			08/08/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R		1	GRACE ST		
DENISSE	LAER CARE CENT	ED		1	ELAER, IN47978		
KENSSE	LAER CARE CENT	LK		KENSS	ELAEN, IN47976		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The resident was	s readmitted to the facility			notified on 8.2.11 to hold lasi		
	on 7/17/11. The	August 2011 Physician's			digoxin related decrease in v		
	Order Summary (POS), indicated an order				signs and level of conscious		
	was dated 7/17/11 indicating the resident				2. How Facility reviewed al	•	
	was a "full code."				residents who could be	al	
	was a Tull code.				affected by the same allege deficient practice. On Augus		
	1 1 17/10/11				th 2011 a 100% audit was	או וט	
	An interim care plan dated 7/19/11,				conducted of Medication		
	indicated the res	ident's advanced directive			Administration Records,		
	was listed as do	not resuscitate.			Treatment Administration		
					Records, Advanced Directive	es,	
	The social service	e progress noted dated			and Dietary Supplements. 3.	Α	
	The social service progress noted dated 7/27/11, indicated the resident was a do				systemic change the facility	,	
	·	d the resident was a do			has made to ensure the alle	ged	
	not resuscitate.				deficient practice does not		
					occur. In-Service was condu		
	Interview with th	ne Administrator on			for nursing staff, dietary man	ager	
	8/3/11 at 9:00 a.1	m., indicated a			and Staff Development		
		er had been obtained and			Coordinator regarding Medic	ation	
		rent advance directive			Administration/Treatment		
		Tent advance directive			Documentation. Physician Orders, Dietary Supplements	e and	
	was full code.				Advanced Directives on Thui		
					8.18.11 by the SDC. 4. How		
					corrective actions will be		
					monitored to ensure that		
					alleged deficient practice w	ill	
					not reoccur Nursing		
					Administration will monitor		
					Medication		
					Administration/Treatment		
					documentation, and New Or		
					for Supplements in addition t		
					nursing administration will als		
					monitored by Dietary Managorith Change of Condition during		
					clinical meeting M-F. Social	"'Y	
					Service and nursing Departm	nent	
					will monitor Advance Directiv		
					during change of condition,	-	
					J		

000185

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
		155287	1			08/08/2	011	
		10020	B. WIN			00.00.2		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
			1309 E GRACE ST					
RENSSELAER CARE CENTER			RENSSELAER, IN47978					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID		(X5)		
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	· · · · · · · · · · · · · · · · · · ·		DATE	
TAG	2. On 8/2/11 at 1 was observed in can of Glucerna supplement, on table. The record for R on 8/2/11 at 10:5 Interdisciplinary reviewed. A proindicated the result of Glucerna three note dated 7/28/continues to record a day.	L:55 p.m., Resident #4 her room. There was a , a liquid dietary the resident's bedside		TAG	admission and re-admission process with chart review duclinical meeting M-F. Monito will last for 4 weeks and if 10 compliance is achieved be reduced to 3 times per week weeks, if 100% compliance achieved be reduced to 1 timper week for 4 weeks. If 100 compliance is achieved the Performance Improvement Committee will review and diffurther monitoring is neces 5. By what date the system changes will be completed Date of compliance 8.31.11	uring ring 00% a for 4 dis ne % ecide dissary. dic	DATE	
		hysician's orders dated 3/2/11, indicated there was						
	no physician ord	ier for Glucerna.						
	LPN #2 was inte	erviewed on 8/2/11 at 2:45						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SM4M11 Facility ID:

000185

If continuation sheet

Page 52 of 55

AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ON WAY OF THE STRUCTION ON WAY OF THE STRUCTION (X3) DATE STRUCTION COMPLE ON WAY OF THE STRUCTION O		ETED		
155287		B. WING			08/08/2	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
RENSSELAER CARE CENTER					GRACE ST ELAER, IN47978		
(X4) ID			-	ID I	·		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG			1	TAG	DEFICIENCY)		DATE
	1 *	ed she administered					
		esident as a dietary					
	supplement.						
	Interview with the Director of Nursing on						
		n., indicated there was no					
		for the resident to have					
	Glucerna three ti						
		1 7					
	3. The record for	Resident #26 was					
	reviewed on 8/2/	11 at 9:30 a.m. A					
	physician order, written by the podiatrist and dated 6/28/11, indicated the resident was to have Clotramazole 1% cream to his toes and feet daily x 1 week. Review of the June 2011 and the July 2011 Treatment Administration Records indicated the treatment was not done as						
	ordered.						
	Interview with the Director of Nursing on 8/3/11 at 8:45 a.m. indicated the attending physician did not want the treatment of the Clotramazole to be completed. She						
	indicated the atte						
		treatment. She indicated					
	discontinue the t	tten physician order to					
	aiscontinue the ti	Calificiil.					
	4. The record for Resident #2 was reviewed on 8/2/11 at 10:30 a.m. A physician order, dated 6/28/11, indicated						
	the resident was	to receive Gentamycin					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287				(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
		A. BUII B. WIN			08/08/2011			
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1	GRACE ST			
RENSSELAER CARE CENTER				RENSS	ELAER, IN47978			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
	(an antibiotic) eye drops, 2 drops to each							
	eye four times a day for 7 days.							
		ly 2011 Medication						
		Record indicated the						
		the eye drops July 1						
	through July 5, 2	011.						
	Review of the In	ne 2011 Medication						
		Record indicated there						
		tation the resident						
	received the Gentamycin eye drops on June 29 and 30, 2011.							
		ne Assistant Director of						
	Nursing on 8/3/11 at 2:30 p.m. indicated there was no documentation on the June							
		Administration Record						
	that the resident received the Gentamycin eye drops on 6/29/11 and 6/30/11. 5. Resident #9's record was reviewed on 08/02/11 at 2:50 p.m. The resident's diagnoses included, but were not limited to, severe chronic kidney disease and atrial fibrillation.							
	The resident's Ph	ysician's Recapitulation						
		/11 indicated orders for						
	· ·	nedication) 125 mcg						
		ily and furosemide						
	(diuretic) 40 mg (milligrams) daily. The orders were originally written on							
	10/01/10.							

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155287		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING 00 08/08/2011			LETED			
NAME OF PROVIDER OR SUPPLIER RENSSELAER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN47978					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
TAG	The Medication (MAR), dated 07 Digoxin and the (circle around the 29, and 30, 2011 There was a lack MAR and in the to indicate why theld. During an interval, the Director indicated the nurresident's physic received an order furosemide due to in the resident's condicated the nurresident's condicated t	Administration Record 7/11, indicated the furosemide had been held e initials), on July 27, 28,	TAG	DEFICIENCY	AFROFINAL	DATE		

000185